



## NEW HAMPSHIRE HEALTHFIRST PLAN OPEN ACCESS PLUS IN-NETWORK MEDICAL BENEFITS

### The Schedule

#### For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the following toll free number :[ 1-800-244-6224] as shown (on the back of your I.D. card) to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

#### Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

#### Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

#### Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any:

- Coinsurance.
- inpatient hospital facility deductibles.
- outpatient facility deductibles.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- non-compliance penalties.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.

#### Contract Year

Contract Year means a twelve month period beginning on each [10/01].

#### Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.



BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Lifetime Maximum</b>	Unlimited
<b>Coinsurance Benefit Level</b>	None
<b>Contract Year Deductible</b>  Individual – Care received from Tier 1 Hospitals/Facilities  Individual – Care received from Tier 2 Hospitals/Facilities  Family Maximum – Care received from Tier 1 Hospitals/Facilities  Family Maximum – Care received from Tier 2 Hospitals/Facilities  <b>*NOTE: A list of Tier 1 and Tier 2 Hospitals/Facilities appears at the end of this certificate</b> <b>*NOTE: All hospitals located out of state shall be assigned to tier 2.</b>  Family Maximum Calculation <b>Individual Calculation:</b> Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	\$2,500 per person  \$4,000 per person  \$5,000 per family  \$8,000 per family
<b>Out-of-Pocket Maximum</b>  Individual – Care received from Tier 1 or Tier 2 Hospitals/Facilities  Family Maximum – Care received from Tier 1 or Tier 2 Hospitals/Facilities  <b>*NOTE: A list of Tier 1 and Tier 2 Hospitals/Facilities appears at the end of this certificate</b>  Family Maximum Calculation <b>Individual Calculation:</b> Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	\$5,000  \$10,000 per family



BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Physician's Services</b> Primary Care Physician's Office visit Specialty Care Physician's Office Visits (includes Consultant and Referral Physician's Services) <b>Note:</b> OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CG. There will be no charge for any routine services performed. Surgery Performed In the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Treatment/Injections Allergy Serum (dispensed by the Physician in the office)	No charge after \$20 per office visit copay No charge after \$50 per office visit copay No charge after the \$20 PCP or \$50 Specialist per office visit copay No charge after the \$20 PCP or \$50 Specialist per office visit copay No charge after either the \$20 PCP or \$50 Specialist per office visit copay or the actual charge, whichever is less No charge
<b>Preventive Care</b> Immunizations, Lead Screenings, PSA tests, Routine Physical Exams (including family planning, prenatal and well child care), Women's Health (including mammography), Routine Hearing, Routine Laboratory tests, Routine Care for Chronic Illness including an Annual Care Plan	No charge
<b>Inpatient Hospital - Facility Services</b> Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	No charge after applicable deductible Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate
<b>Outpatient Facility Services</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	No Charge after applicable deductible
<b>Inpatient Hospital Physician's Visits/Consultations</b>	No charge after applicable deductible
<b>Inpatient Hospital Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	No charge after applicable deductible



BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Outpatient Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	No charge after applicable deductible
<b>Emergency and Urgent Care Services</b>  Physician's Office Visit  Hospital Emergency Room  Outpatient Professional services (radiology, pathology and ER Physician)  Urgent Care Facility or Outpatient Facility  X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)  Independent x-ray and/or Lab Facility in conjunction with an ER visit  Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)  Ambulance	No charge after the \$20 PCP or \$50 Specialist per office visit copay  No charge after \$200 per visit copay* *waived if admitted  No charge after applicable deductible  No charge after \$100 per visit copay* *waived if admitted  No charge after plan deductible  No charge  No charge after plan deductible  No charge after plan deductible
<b>Inpatient Services at Other Health Care Facilities</b> Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Contract Year Maximum: Skilled Nursing Facility and Sub-Acute Facilities – 100 days Rehabilitation Hospital – 60 days	No charge after applicable deductible



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BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Hospice</b> Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	No charge after applicable deductible No charge after applicable deductible
<b>Bereavement Counseling</b> Services Provided as part of Hospice Care Inpatient Outpatient Services Provided by Mental Health Professional	No charge after applicable deductible No charge after applicable deductible Covered under Mental Health benefit
<b>Maternity Care Services</b> Initial Visit to Confirm Pregnancy <b>Note:</b> OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CG. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist Delivery - Facility (Inpatient Hospital, Birthing Center or Home)	No charge  No charge No charge No charge after applicable deductible
<b>Abortion</b> Includes elective and non-elective procedures Physician's Office Visit  Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$20 PCP or \$50 Specialist per office visit copay No charge after applicable deductible No charge after applicable deductible No charge after applicable deductible



BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Family Planning Services</b>  Office Visits, Lab and Radiology Tests and Counseling  <b>Note:</b> The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.  Surgical Sterilization Procedure for Vasectomy/ Tubal Ligation (excludes reversals)  Physician's Office Visit  Inpatient Facility  Outpatient Facility  Physician's Services	No charge           No charge  No charge after applicable deductible  No charge after applicable deductible  No charge after applicable deductible
<b>Infertility Treatment</b> Services Not Covered include: <ul style="list-style-type: none"><li>• Testing performed specifically to determine the cause of infertility.</li><li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li><li>• Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</li></ul> <b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered



BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Organ Transplants</b> Includes all medically appropriate, non-experimental transplants  Physician's Office Visit  Inpatient Facility – Lifesource Centers Only Inpatient Facility – Non-Lifesource  Physician's Services  Lifetime Travel Maximum: \$10,000 per lifetime	   No charge after the \$20 PCP or \$50 Specialist per office visit copay  100%  No charge after applicable deductible  100% at Lifesource center, otherwise 100% after applicable deductible  No charge (only available when using Lifesource facility)
<b>Durable Medical Equipment</b> Limited to \$3000 per member perContract year.	No charge after applicable deductible
<b>External Prosthetic Appliances</b> Contract Year Maximum: Unlimited	No charge after applicable deductible
<b>Dental Care</b> Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.  Physician's Office Visit  Inpatient Facility Outpatient Facility Physician's Services	   No charge after the \$20 PCP or \$50 Specialist per office visit copay  No charge after applicable deductible No charge after applicable deductible No charge after applicable deductible
<b>Routine Foot Disorders</b>	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
<b>Treatment Resulting From Life Threatening Emergencies</b>  Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.	



BENEFIT HIGHLIGHTS		IN-NETWORK	
<b>Mental Health (Biologically Based)</b>			
<b>Inpatient</b> Contract Year Maximum: Unlimited		No charge after the applicable deductible	
<b>Outpatient</b> Contract Year Maximum: Unlimited		No charge after the \$20 per visit copay	
Outpatient Group Therapy (One group therapy session equals one individual therapy session)		No charge after the \$20 per visit copay	
<b>Mental Health (Not Biologically Based)</b>			
<b>Inpatient</b> Contract Year Maximum: Unlimited		No charge after the applicable deductible	
<b>Outpatient</b> Unlimited		No charge after the \$20 per visit copay	
Outpatient Group Therapy (One group therapy session equals one individual therapy session)		No charge after \$20 per visit copay	
<b>Substance Abuse</b>			
<b>Inpatient</b> Contract Year Maximum: Unlimited		No charge after the applicable deductible	
<b>Outpatient</b> Contract Year Maximum: Unlimited		No charge after \$20 per office visit copay	
<b>Body Mass Index Screening</b>		No charge	



## Prescription Drug Benefits

### The Schedule

#### For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-day supply at a retail pharmacy or a mail order pharmacy. That portion is the Copayment or Coinsurance.

Note: Each 30 day supply will require a copayment regardless if it is from a retail or mail order pharmacy. (i.e. a 90 day supply whether at a retail or mailorder pharmacy will require 3 separate copayments)..

#### Copayments

Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Copayments are in addition to any Coinsurance.

#### Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with the parameters established by the Pharmacy and Therapeutics Committee. The Prescription Drug List is regularly reviewed and updated. The most current information regarding the Prescription Drug List can be found at [www.CIGNA.COM](http://www.CIGNA.COM).

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
<b>Prescription Drugs</b>		
<b>Out-of-Pocket Maximum</b>		
Individual	\$5,000	In-network coverage only
Family	\$10,000	In-network coverage only
<b>Tier 1</b>		
Generic* drugs on the Prescription Drug List	No charge after \$10 per prescription order or refill	In-network coverage only
<b>Tier 2</b>		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$35 per prescription order or refill	In-network coverage only
<b>Tier 3</b>		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after \$50 per prescription order or refill	In-network coverage only
*Designated as per generally-accepted industry sources and adopted by CG		



BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
<b>Mail-Order Drugs</b> <b>Tier 1</b> Generic* drugs on the Prescription Drug List	No charge after \$30 per prescription order or refill	In-network coverage only
<b>Tier 2</b> Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$105 per prescription order or refill	In-network coverage only
<b>Tier 3</b> Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after \$150 per prescription order or refill	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by CG		



[Listing of Tier 1 and Tier 2 Hospitals]

<b>Hospital Name</b>	<b>Hospital Tier</b>
Alice Peck Day Memorial Hospital	1
Androscoggin Valley Hospital	1
The Cheshire Medical Center	1
Catholic Medical Center	2
Concord Hospital	1
Cottage Hospital	1
Dartmouth Hitchcock Medical Center	2
Elliot Hospital	1
Exeter Hospital	2
Frisbie Memorial Hospital	2
Huggins Hospital	1
Littleton Regional Hospital	2
Franklin Regional Hospital	2
Lakes Region General Hospital	1
The Memorial Hospital	1
Monadnock Community Hospital	1
New London Hospital	1
Parkland Medical Center	1
Portsmouth Regional Hospital	2
Southern NH Medical Center	1
Speare Memorial Hospital	1
St. Joseph Hospital	2
Upper Connecticut Valley Hospital	1
Valley Regional Hospital	1
Weeks Medical Center	1
Wentworth-Douglas Hospital	1